Gasior Declaration

Exhibit H-154-4

EXHIBIT D

COUNTY OF ROCKLAND
DEPARTMENT OF SOCIAL SERVICES

The Dr. Robert L. Yeager Health Center
Building L - Sanatorium Road
P.O. Box 307
Pomona, New York 10970-0307
Telephone: (845) 364-2000

C. SCOTT VANDERHOEF
County Executive

SUSAN SHERWOOD
Commissioner

Managed Care Unit
Direct Line: (845) 364-3243
Fax Number: (845) 364-3984
Not for Service of Process

December 28, 2011

Tasha Ostler
624 Sierra Vista Lane
Valley Cottage, NY 10989

Re: Health Insurance premiums
Case Number: M0060692

Dear Tasha Ostler:

After a review of your file, it has been determined that it is cost effective for this department to pay for your health insurance premium at this time. Please fill out the enclosed W-9 and return in the self-addressed envelop.

Therefore, payment will be made upon receipt of your bill and proof of payment.

Please remember we can no longer accept fax copies.

If you have any questions please do not hesitate to call (845) 364-3243.

Very truly yours

NOTICE OF DECISION FOR FAMILY HEALTH PLUS – PREMIUM ASSISTANCE PROGRAM

NOTICE DATE: 12-28-11 | EFFECTIVE DATE: 12-01-11

CASE NUMBER: M00600692 | Unit or Worker Name: MANAGED CARE

CASE NAME (And C/O Name If Present) AND ADDRESS:
JACKSON MAIONE
C/O TASHA OSTLER
624 SIERRA VISTA LANE
VALLEY COTTAGE, NY 10989

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE:
ROCKLAND COUNTY DSS
P.O. BOX 307
PEARL RIVER, NY 10970

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP

OR Agency Conference (845) 364-3243
Fair Hearing Information and Assistance (800) 342-3334
Record Access (845) 364-3342
Legal Assistance Information (845) 634-3627

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.
			BARRY CONLOY	845 364-3243

The Local Department of Social Services (LDSS) has made a decision concerning your eligibility for Family Health Plus Premium Assistance Program.

This Department will:

☒ **ACCEPT** the application dated 12-14-2011 for (name(s)) JACKSON MAIONE.
Effective: 12-01-2011, the premium assistance program will pay $634.46 ☐weekly ☐bi-weekly ☒ monthly ☐quarterly

☐ **DENY** the application dated _____ for (name(s)) _____.
The reason for this action is as follows:

☐ It is not cost effective for Medicaid to pay the premium for your employer sponsored health insurance plan.

☐ **CONTINUE** the premium payment for (name(s)) _____, effective _____. The premium assistance program will pay $_____ ☐weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **TAKE NO ACTION** on the application dated _____, since it was withdrawn.

☐ **CHANGE** from Family Health Plus Managed Care to Family Health Plus Premium Assistance Program for (name(s)) _____. You will be disenrolled from _____ Health Insurance Plan effective: _____ and enrolled in your Employer's Health Insurance Plan _____, effective: _____. The Premium Assistance Program will pay $_____ ☐ weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **DISCONTINUE** Premium Assistance Program for (name(s)) _____
Effective _____. The **reason** for this action is as follows:

☐ You no longer have access to your employer's health insurance plan; you will be enrolled into the Family Health Plus plan you chose on your application.

☐ You no longer have access to your employer's health insurance plan. You must complete the enclosed Family Health Plus Plan enrollment form and return it within 10 days to the address listed above if you want to receive Family Health Plus benefits.

☐ It is not cost effective for Medicaid to continue paying the premium for your employer sponsored health insurance plan. You must notify us **within 10 days** to tell us if you will remain in the employer sponsored health insurance and pay the cost of the premium yourself. If you fail to respond your coverage will end. If you choose to discontinue your health insurance, you must provide us with written proof of your termination date, and you must choose a Family Health Plus plan **within 10 days** if you want to receive Family Health Plus benefits.

☐ It is not cost effective to continue to pay for your premium.